

Missouri Medical Malpractice Joint Underwriting Association

Minutes for the Meeting of June 6, 2004

- Location:** The Offices of Missouri Employers Mutual Insurance Company
(made available by Vice Chairman Dennis Smith, CEO of MEM)
1000 West Nifong, Building 7
Columbia, MO 65203
- Time:** 10:30 a.m.
- Attending:** Bill Turley, Chairman [Shelter Insurance Companies/NAII]*
(Board) Don Ainsworth [Safety National Casualty Corp./the Alliance]
Dave Monaghan [American Family Insurance/NAII]
Dennis Smith (*via teleconference*) [Missouri Employers Mutual/AIA]
Patty Williamson [Uhlemeyer Services, Inc./AIA]
- (MDI Staff)** Linda Bohrer, Director, MDI Division of Market Regulation
Susan Schulte, Chief, MDI Property & Casualty Section
Mark Doerner, Senior Counsel, MDI P&C Section
- (Audience)** Keith Wenzel, Hendren & Andrae
Jean-Paul Rebillard, Marsh
Mike Granacher, Marsh
Sheryl Manger, Marsh
Andrew Teigen, Marsh
Jim Vaccarino, (*via teleconference*) Marsh
Tom Hermes, (*via teleconference*) Tillinghast
Scott Dodge, Tillinghast

The meeting, originally scheduled to begin at 10:00 a.m., began at roughly 10:30 when a quorum of the Board was finally present. Chairman Turley started the meeting with a review of the contract negotiations with Marsh. He indicated he had had a telephone discussion with Jean-Paul Rebillard of Marsh the previous Friday afternoon, during which an agreement was reached. Marsh agreed to the Chairman's request that the element of Marsh's compensation package which is based on a percentage of premium be based on "earned premium" and not "written premium." In addition, Marsh agreed to lower the rate of reimbursement from 10% to 8% of premium. The contract also

* Material in brackets following the names of Board members indicate the insurance companies they work for and then the insurance industry trade groups that they are representing under Section 383.175, RSMo.

contained the cross-indemnity language requested by Marsh. Keith Wenzel, the Board's attorney passed out copies of the contract. In response to a question from Dave Monaghan, it was pointed out that the premium basis on which Marsh is reimbursed does not include the additional first year charge (i.e., the "surcharge") required under Section 383.165, RSMo. On a motion by Don Ainsworth, seconded by Patti Williamson, the Board took a voice vote in favor of approving the contract, with no opposition. Following the vote, Chairman Turley signed a copy of the contract on behalf of the Board, followed by Andrew Teigen, who signed it on behalf of Marsh.

The next item on the agenda was a discussion of the manual and form documents filed with the Department of Insurance. Andrew Teigen and Sheryl Manger discussed a draft of a claims-made policy that had been re-worded to track the language of Section 383.160, RSMo to make it clear that the "policy period" (during which the malpractice event must occur to be covered) covers not only the one year period of the contract, but also prior policy periods back to the policy's "retro" date. Other than clarifying the "policy period," the draft policy functioned as a typically medical malpractice claims-made policy.

Dave Monaghan asked for some clarification as to why a claims-made form was being discussed. Sheryl pointed out that, regardless of whether the Board decided at some future point to offer a stand-alone claims-made policy, the JUA would need the form being proposed in order to make "nose" coverage available as "incidental coverage" under Section 383.155, subsection 3. The "nose" coverage would be made available to those providers who are unable to obtain tail coverage from their previous claims-made insurer before coming to the JUA for occurrence coverage.

With the changes made to the claims-made policy form to help clarify that the coverage falls within the requirements of Section 383.160, subsection 1, the discussion then turned to whether it was necessary to seek a court ruling on whether it was permissible for the JUA to make stand-alone claims-made coverage available. The consensus of the Board was to proceed on the course the Board had previously agreed to, with the JUA issuing occurrence policies first, with the modified claims-made policy used only to provide nose coverage as an incidental coverage to the underlying occurrence policy.

The Board then discussed the cost that would be faced by a provider coming to the JUA. Whether the provider obtains tail coverage from his or her prior carrier or nose coverage from the JUA, the expense will be roughly the same. And, the JUA's occurrence rates will approximate "mature" claims made rates. Dennis Smith asked how this would be explained to the providers. The Department indicated it planned to issue a press release regarding the start up of the JUA, and might cover frequently asked questions (FAQs). Dennis Smith mentioned that MEMIC went out into the various state locations to meet with insureds and associations of insureds. Marsh asked whether it should do a mailing to Missouri providers. In response, the Department noted the provision of the Plan of Operations that allowed for the dissemination by the JUA of written information to providers.

Sheryl Manger of Marsh distributed a draft of the underwriting manual and discussed its provisions, and accepted suggestions for modifications. Regarding the additional first year surcharge required under Section 383.165, it was determined that if the policy cancelled early, the surcharge would be refunded pro rata. (Since by statute, the surcharge is to be equal to the first year premium, if the first year premium is cut, say, in half due to an early cancellation, the surcharge, which is to be equal to that premium, would also be cut in half.)

As an aside, Dennis Smith inquired about the JUA's tax status. MDI discussed the provisions of Section 501(c) of the Internal Revenue Code. Dennis suggested a tax expert who could be used to try to answer the question.

Sheryl Manger then discussed policy form language. One question she raised was whether it was permissible to cancel a policy due to material misrepresentations, made by the insured health care provider. Based on her reading of the Plan of Operations, such a cancellation would not be permitted. Dave Monaghan responded that the Board recognized when it was working on the Plan of Operations that it wouldn't be able to think of everything that might come up during the underwriting process, which is why it added language allowing "other reasonable underwriting guidelines" to be contained in the underwriting manual. The discussion then turned to what types of material misrepresentations might warrant cancellation, what type of notice would be given, and other specific details. Jim Vaccarino of Marsh said that JUAs that basic coverage availability on the insured's status as a "licensed" health care provider generally don't cancel for misrepresentations other than one related to the provider's licensure status itself; rather, instead of canceling the coverage, the JUAs simply re-rate the policy to increase the premium to what it should have been had the JUA be given the correct information (say, about past claims history).

Chairman Turley pointed out that Sections 383.155 and 383.170 permit the JUA to have "reasonable and objective underwriting standards." Dennis Smith said that if we allowed addition criteria beyond licensure status and payment of premium, the JUA would not be a "classic" JUA, but rather, a "hybrid," which might not be permissible under federal tax-exempt status. Given a lack of tax expertise at the meeting, further research of the federal tax law was clearly needed. However, Dave Monaghan voiced the notion the Board should make a decision on the issue of material misrepresentations regardless of the whether there was a federal tax effect, particularly since, in Marsh's experience in other states, most other JUAs are not federally tax-exempt. Dennis Smith said that, if the statutes allow reasonable underwriting standards, we could add an underwriting standard regarding misrepresentations. The meeting then shifted to the various situations under which the underwriting guideline should allow a policy to be found void *ab initio*, cancelled or up-rated. Dave suggested that Marsh draft some language on this issue and provide it to the Board after the meeting.

Next, the Board heard from Scott Dodge and Tom Hermes of Tillinghast regarding the actuarial analysis they had done to determine the rates the JUA would need to charge. Scot Dodge handed out two items; one was a letter to Sheryl Manger regarding the

expense differences between the JUA and a typical carrier in the “admitted” market and the other was a series of bullet points on their rating methodology. Their goal was to come up with rates for the “average” risk. They decided to look at the major insurers in Missouri and select one of them as a starting point. They selected Medical Assurance and then looked at the expenses Medical Assurance would have to include in their rates that the JUA would not have to charge. They also worked with Marsh to determine what schedule rating and experience rating provisions would be applied to non-standard risks.

Scott Dodge reviewed the rate indication. Regarding the various expenses items the JUA would or would not incur compared to a typical admitted carrier in the voluntary market like Medical Assurance. Tillinghast first added 6.3% to the JUA’s expenses since this was the conversion factor provided in the Medical Assurance rate filing to be used to convert the mature claim-made rates of the filing to the type of “occurrence” rates planned for the JUA. Tillinghast reduced the “commission” expense from 8% to 3.5% to reflect the fact that the JUA planned to pay a 5% commission, but also anticipated a significant number of applications by providers who did not use agents. They eliminated the 5% DD&R (Death, Disability and Retirement) loading factor included in claims-made rates to provide a free tail to providers who die, are disabled or who retire (after having been with the carrier 5 to 10 years), since this loading is not needed on an occurrence policy. They also eliminated 6% from the profit and contingency loading. They retained the 3.6% load for “taxes, licenses and fees,” but recognized that the meeting’s earlier discussions raised the possibility that the taxes paid by the JUA might not be the same as those paid by an admitted carrier. The net effect was that the an occurrence policy from the JUA would be at least 9.2% less expensive than a typical voluntary market mature claims-made policy. After Scott Dodge’s presentation, Tom Hermes of Tillinghast indicated that one of the assumptions used in the analysis was that the JUA would represent a substantial book of business, such that it would have typical operating expenses.

Scott Dodge continued with a discussion of rates for hospitals and other facilities. He indicated Tillinghast’s understanding that the bulk of the coverage written in this areas was written by the Missouri Hospital Plan, so he used their rates as a basis for the proposed JUA rates. Rating adjustments via schedule rating and experience rating were mentioned.

Regarding the long-term care market, including nursing homes, he indicated no filings by other carriers in recent years. While they had heard that premiums in this area have been increasing, this was apparently being done through the removal of schedule credits and other individual policy adjustments, not via new rate levels. Here, Tillinghast had their own body of data on the relationship between a normal hospital bed rate and a nursing home rate to allow long-term care facility rates and skilled care facility rates to be estimated.

Finally, they developed rates for general liability coverage as an incidental coverage. These are typically small claims that do not represent a significant amount of this market’s losses. The loss ratio is typically 30%.

Thereafter, their plan would be to monitor the JUA's premiums and losses on a quarterly basis to follow developments.

Sheryl manger of Marsh picked up the discussion by noting where in the draft manual the rating provisions were set forth. The rating classifications used were similar to Medical Assurance's. The rates that followed were roughly 10% below the mature claims-made rates that Medical Assurance filed with MDI for Missouri in October of 2003. She briefly noted the sections on specific provider types, such as dentists and allied health professionals. She then discussed the credits for things like part-time practices, practice interruptions (e.g., for military service), being loss-free for a period of time, etc.

Regarding surcharges, Susan Schulte of the Department pointed out that MDI Director Scott Lakin's concern about the common practice of surcharging doctors who have claims filed against them. (The Director's concern is that having a "claim" filed against a provider doesn't mean the provider is legally responsible for malpractice, and that therefore, a surcharge is premature.) The Board indicated it might study this point as the JUA gains more experience.

Regarding experience rating, Sheryl noted that it does excuse two losses of \$10,000 or less each, as well as class actions. Regarding the schedule rating plan, surcharges are assessed for license lapses, revocations, denials, chemical problems etc. that are reported on an application. Chairman Turley suggested tying the surcharge to actual behavior, and not self-reported behavior. It was decided that earlier decision to allow up-rating in cases of misrepresentations would cover the Chairman's concerns, but he suggested a removal of the "reporting" requirement, and similar provisions. Sheryl agreed to delete these.

The Chairman also observed that the fact the schedule rating plan applied a surcharge for certain acts might imply that not other action by the JUA (such as cancellation) was permitted. It was suggested that the schedule rating increases be "...in addition to other discipline available...."

Next, Sheryl discussed *locum tenens* coverage, which is normally not charged for by carriers. Next, a section called "organizational coverage" was noted, which explains how doctor corporations are rated (with separate limits for the doctors and the corporation if there is more than one doctor involved).

The facility rates and rating rules, as explain above, are based on those used by the Missouri Hospital Plan. The rates are per-bed and per-outpatient visit. The Board members were surprised at the various cities and counties included in the rating territories. Patti Williamson said that it was probably the result of the state's "venue" laws. In passing, it was noted that a "the rest of the state" notation needed to be added to the locations included under "Territory 6."

Sheryl then pointed out the schedule rating plans for facilities and noted that an experience rating plan would need to be added. General liability rates for facilities would

be 10% of the professional liability premium. (Physicians groups can buy a small BOP policy.)

At this point, Dave Monaghan went back to the presentation by Tillinghast and recommended that the numbers used in the JUA's presentations on its rates omit the type of "indicated"/"selected" distinctions normally included in actuarial analyses, since the target audience (health care providers, the public) are unfamiliar with this distinction and therefore might be confused or perceive any difference between the two as arbitrary or indicative of inadequate rates. The consensus was to use whatever number is indicated by the actuarial analysis.

After Sheryl's presentation, Don Ainsworth made a motion to approve the manual, subject to Marsh making the changes recommended at the meeting. Patty Williamson seconded the motion and, after a voice votes with no opposition, the manual was approved. On a second motion, the Board voted for and approved the forms, subject to the modifications discussed, with no opposition.

Next, Andrew Teigen of Marsh discussed the percentage rate to be charged on the interest on the promissory note. First, he offered the interpretation that the health care provider would owe no interest on the note until after the first 12 months, because the statute gives them the first year of the policy to pay the additional first year charge (i.e., the surcharge). The Chairman disagreed, and said we should require the full note at the time the first year premium or first premium installment is paid. Regarding the "rate" of interest, it was decided that Marsh should tie the rate to some outside rate, so it could fluctuate. Marsh said it would report back on alternative market indexes.

Keith Wenzel discussed the text of the draft promissory note. The Chairman suggested requiring the personal signatures of the healthcare provider(s) and the provider spouse(s) (even if it's a professional corporation). The Chairman also said it should be a "demand" note.

Andrew Teigen then discussed an alternative name for the JUA, "MMEDIC," a name and URL that were available. It would stand for the Missouri Medical Insurance Company. Don Ainsworth suggested "JUA" defines the entity better, and the Chairman noted the various places we would have to change the name (for example, in the Plan of Operations). The consensus was to continue to use "MMM JUA."

Finally, they discussed the web site. It was suggested that the site have the ability to receive comments for future fine-tuning. If problems are noted, the site will be fixed.

With that the Board adjourned. No date was set for the next meeting although some time in the next few weeks was mentioned.

